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PAEREWA PĀRONGO HAUORA

MINISTRY OF HEALTH
MANATŪ HAUORA

National Specialist Palliative Care Data Definitions Standard

HISO 10039.2

To be used in conjunction with
HISO 10039.1
National Specialist Palliative Care Business Process Standard

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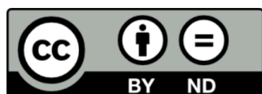

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National Palliative Care Data Working Group

The National Palliative Care Data Working Group was responsible for providing technical advice for this document. Representatives from Northland, Canterbury, Auckland, Wellington, Hawkes Bay, MidCentral, Waikato, Hospice New Zealand and the Ministry of Health were involved in the Working Group.

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Programme representation

The Ministry of Health Cancer and Palliative Care Programme team members who were responsible for assisting the working group with the preparation of this Standard were:

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Updates

Date	Version	Page number	Section number	Changes
December 2011	1.0			Published as 'Interim' Standard
June 2013	2.0			Changed status from 'Interim' Standard to 'Full' Standard

1 INTRODUCTION

The National Specialist Palliative Care Data Definition Standard is intended to ensure that minimum agreed specialist palliative care data is collected and stored in a consistent manner wherever it is collected and stored. The Standard encompasses and defines essential elements of service delivery. The associated business process document provides context for the data definition standard and describes the business processes involved in the collection and storage of palliative care data.

In doing so the specialist palliative care core data definition set will;

- provide a basis of a common language for discussions between stakeholders and for understanding palliative care in New Zealand
- provide a framework for communication between information systems
- be clear, simple and easy to use
- apply to local, regional and national levels
- be adaptable and be able to be expanded
- align with national and international terminology

This standard defines the elements of palliative data that will be collected, stored and exchanged, providing an overview of each grouping of data items (e.g. name items), as well as:

(a) a definition of each data item

(b) attributes of each item, such as the maximum length of the field, the type of data it holds, the data domain (free text, code table, etc) and layout

(c) information about the source of the defined element attributes

(d) information such as guides for use, rules for verification

(e) the following structure has been used in this document to record the attributes of each data item.

Definition:	A brief description of the data item.		
Source standards:	The source standards from which the data item was sourced or derived.		
Data type:	Alphanumeric Alphabetic Numeric Date Boolean	**Representational class:**	Text Number Date Y/N Code
Field size:	The maximum number of characters available.	**Representational layout:**	The way in which the contents of the field should be displayed. For example while the Data type might be "Alphanumeric" and the Field size might be "4", the Representational layout could be "ANN.N" where the "." is not saved as data.
Obligation:	Mandatory, Conditional, Optional		
Data domain:	The source of the values that should be available for the data item.		
Guide for use:	A guide to the way in which this data item should be used.		
Verification rules:	A list of the rules governing collection and entry of values for the data item. This attribute should also record prerequisite conditions.		

Note: To ensure that the New Zealand context has been considered when replicating the Palliative Care Outcomes Collaboration (PCOC) codes, a number of the Version 2 codes have been retained while others have been updated to reflect the changes indicated in Version 3. The relevant PCOC version applied is noted under the 'Source standards' section in the tables.

Core Palliative Care Entities

The project used a high level business transaction process and information lifecycle model (Figure 1) to identify likely people, organisations, activities and data collection points involved in the palliative care pathway.
As a result of this process, there are six principal entities and the relationship between those entities is shown below – each Patient will have one or more Episodes of Care and within each Episode of Care there will be one or more Service Contacts. Each Episode of care may also have one or more Diagnoses. Each Service Contact may have one or more Contact Purposes and one or more Provider Occupations.

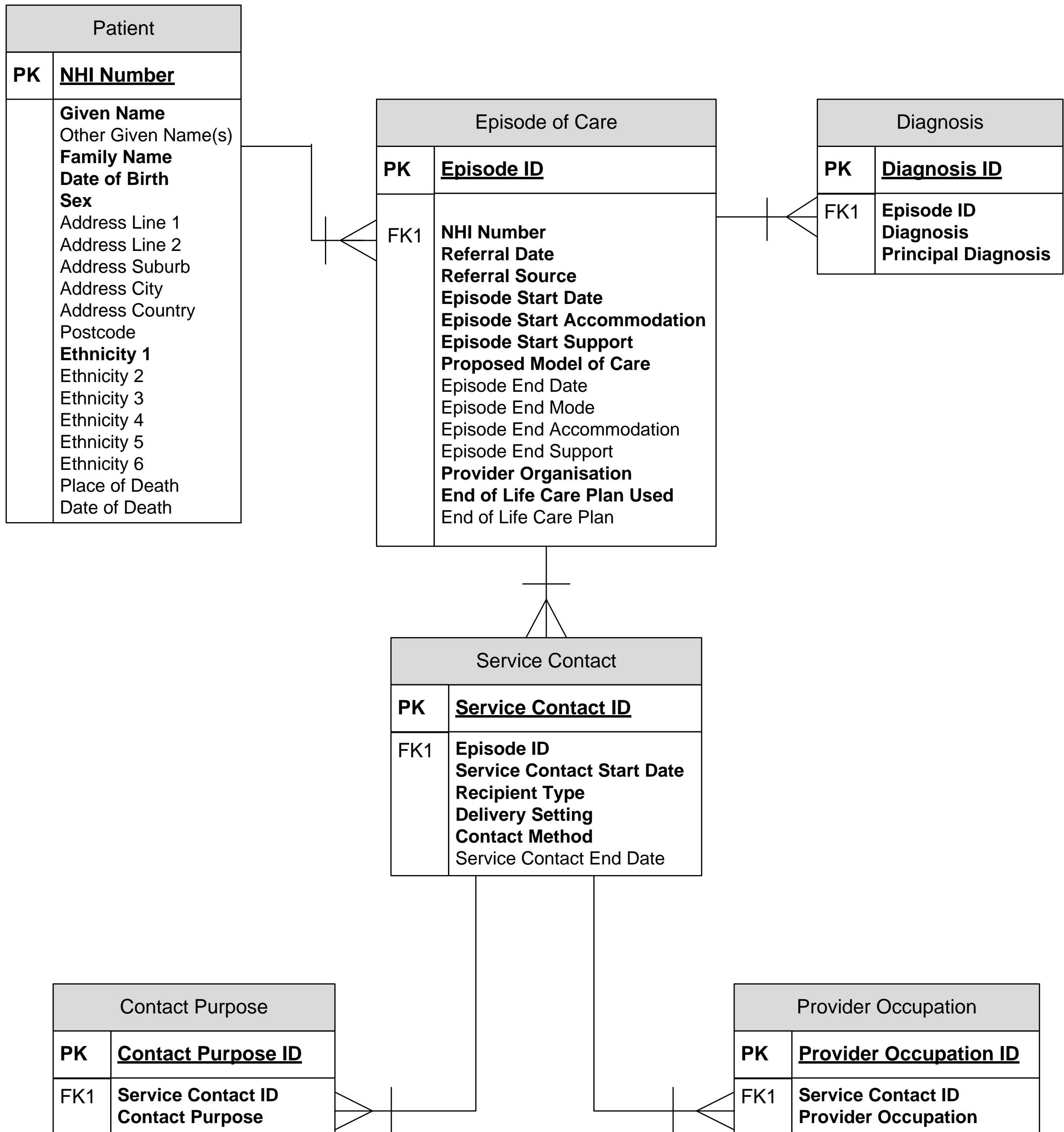

Figure 1: Core Palliative Care Entities

2 PATIENT

The Patient entity contains details of each person receiving palliative care services.

The data elements for 'Patient' are:

1. NHI Number
2. Given Name
3. Other Given Name(s)
4. Family Name
5. Date of Birth
6. Sex
7. Address Line 1
8. Address Line 2
9. Address Suburb
10. Address City/Town
11. Address Country/Region
12. Postcode
13. Ethnicity 1
14. Ethnicity 2
15. Ethnicity 3
16. Ethnicity 4
17. Ethnicity 5
18. Ethnicity 6
19. Place of Death
20. Date of Death

2.1 NHI Number

Definition:	Unique 7-character identification number assigned to a healthcare user by the National Health Index (NHI) database.		
Source standards:	National Health Index Data Dictionary, v5.3, July 2009		
Data type:	Alphanumeric	**Representational class:**	Text
Field size:	7	**Representational layout:**	AAANNNN
Obligation:	Mandatory		
Data domain:	Valid NHI number		
Guide for use:	Primary key for this record, foreign key to related record(s) in the Episode of Care entity		
Verification rules:			

2.2 Given Name

Definition:	The given name of a healthcare user.		
Source standards:			
Data type:	Alphabetic	**Representational class:**	Text
Field size:	40	**Representational layout:**	A(40)
Obligation:	Mandatory		
Data domain:			
Guide for use:	This data element should only be used for the 'given name' (or first name), but not the family name (surname). The data element for 'Other Given [Middle] Name(s) should be used for second and subsequent names or initials, but not the family name (surname).		
Verification rules:			

2.3 Other Given Name(s)

Definition:	The patient's other given names and initials thereof at birth, but not the family name.		
Source standards:			
Data type:	Alphabetic	**Representational class:**	Text
Field size:	40	**Representational layout:**	A(40)
Obligation:	Optional		
Data domain:			
Guide for use:	The data element should only be used for patient's further given names or initials, but not their family name (surname). The patient's given name should be recorded under the data element Given Name (first name). If a patient does not have any second or further given names, this field should be left blank. If there are multiple Other Given Names, separate each entry with a blank space.		
Verification rules:			

2.4 Family Name

Definition:	The family name (surname) of a healthcare user.		
Source standards:			
Data type:	Alphabetic	**Representational class:**	Text
Field size:	50	**Representational layout:**	A(50)
Obligation:	Mandatory		
Data domain:			
Guide for use:	This data element should be used for only the patient's surname, but not for their Given and further 'other given name(s)' or initials. The content must preserve sentence case, for example: 'Maccall' is different from 'MacCall'. The text entered can include one or more spaces, an apostrophe, and / or a hyphen eg, 'Van der Valk', O'Leary, 'Vaughn-Jones'.		
Verification rules:			

2.5 Date of Birth

Definition:	The date on which the person was born		
Source standards:			
Data type:	Date	**Representational class:**	Full date
Field size:	8	**Representational layout:**	CCYY[MM[DD]]
Obligation:	Mandatory		
Data domain:	Valid date		
Guide for use:	The full date of birth (year, month and day) must be recorded if known. Note: If not known, the month and day are conditional. The year of birth is mandatory		
Verification rules:			

2.6 Sex

Definition:	The person's biological sex		
Source standards:			
Data type:	Alphabetic	**Representational class:**	Code
Field size:	1	**Representational layout:**	A
Data domain:	**Value** / **Meaning**: F – Female I – Indeterminate M – Male U – Unknown		
Obligation:	Mandatory		
Guide for use:			
Verification rules:			

2.7 Address Line 1

Definition:	The first line of the address at which a healthcare user has been, or plans to be, living at for 3 months or more. (Statistics NZ definition of 'usually resident'.)		
Source standards:			
Data type:	Alphanumeric	**Representational class:**	Text
Field size:	30	**Representational layout:**	A(30)
Obligation:	Conditional. Mandatory if Address Line 2 is blank – otherwise optional		
Data domain:	Free text		
Guide for use:			
Verification rules:	Address Line 1 and Address Line 2 can not both be blank		

2.8 Address Line 2

Definition:	The second line of the address at which a healthcare user has been, or plans to be, living at for 3 months or more. (Statistics NZ definition of 'usually resident'.)		
Source standards:			
Data type:	Alphanumeric	**Representational class:**	Text
Field size:	30	**Representational layout:**	A(30)
Obligation:	Conditional. Mandatory if Address Line 1 is blank – otherwise optional		
Data domain:	Free text		
Guide for use:			
Verification rules:	Address Line 1 and Address Line 2 cannot both be blank		

2.9 Address Suburb

Definition:	The third line of the address representing the suburb		
Source standards:			
Data type:	Alphanumeric	**Representational class:**	Text
Field size:	30	**Representational layout:**	A(30)
Obligation:	Conditional. Mandatory if Address City/Town is blank – otherwise optional		
Data domain:	Free text		
Guide for use:			
Verification rules:	Address Suburb and City/town cannot both be blank		

2.10 Address City/Town

Definition:	The fourth line of the address, representing the city, town or region. Either the third or the fourth line of the address is mandatory		
Source standards:			
Data type:	Alphanumeric	**Representational class:**	Text
Field size:	30	**Representational layout:**	A(30)
Obligation:	Conditional. Mandatory if Address Suburb is blank – otherwise optional		
Data domain:	Free text		
Guide for use:			
Verification rules:	Address Suburb and City/town cannot both be blank		

2.11 Address Country/Region

Definition:	The fifth line of the address, representing the external region or country		
Source standards:			
Data type:	Alphanumeric	**Representational class:**	Text
Field size:	30	**Representational layout:**	A(30)
Obligation:	Optional		
Data domain:	Free text		
Guide for use:			
Verification rules:			

2.12 Postcode

Definition:	The descriptor for a postal delivery area aligned with the locality, suburb or place for this address.		
Source standards:	HL7 2.5 2.A.1 AD - address		
Data type:	Alphanumeric	**Representational class:**	Code
Field size:	12	**Representational layout:**	AN(12)
Obligation:	Optional		
Data domain:	NZ Post postcode file International postcodes should be recorded as provided		
Guide for use:			
Verification rules:	Data for New Zealand postcodes should be verified against the NZ Post postcode file.		

2.13 *Ethnicity 1*

<table>
<tr><td>Definition:</td><td colspan="3">Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group.
An ethnic group is made up of people who have some or all of the following characteristics:
• a common proper name
• one or more elements of common culture that need not be specified, but may include
• religion, customs, or language
• unique community of interests, feelings and actions
• a shared sense of common origins or ancestry, and
• a common geographic origin. Māori in this report refers to the Māori ethnic group.</td></tr>
<tr><td>Source standards:</td><td colspan="3">Ethnicity New Zealand Standard Classification 2005, ETHNIC05 V1.0, 01/06/2005</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>5</td><td>Representational layout:</td><td>N(5)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Conditional. Record if offered by patient.</td></tr>
<tr><td>Data domain:</td><td colspan="3">See the Ministry of Health’s Ethnicity Data Protocols for the Health and Disability Sector at http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector for a list of valid codes.</td></tr>
<tr><td>Guide for use:</td><td colspan="3">Ethnicity 1 should record the patient’s first stated ethnicity. It is important to note that “first” does not refer to “preferred” – simply the first ethnicity offered by the patient.
If the patient does not offer an ethnicity, record one of the following.
<table><tr><th>Code
(Level 4)</th><th>Description</th></tr><tr><td>94444</td><td>Don't Know</td></tr><tr><td>99999</td><td>Not Stated</td></tr><tr><td>95555</td><td>Refused to Answer</td></tr><tr><td>97777</td><td>Response Unidentifiable</td></tr></table>
Refer to Ethnicity Data Protocols for the Health and Disability Sector, Ministry of Health, 2004 for more guides to use.</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

2.14 *Ethnicity 2*

<table>
<tr><td>Definition:</td><td colspan="3">Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group.
An ethnic group is made up of people who have some or all of the following characteristics:
• a common proper name
• one or more elements of common culture that need not be specified, but may include
• religion, customs, or language
• unique community of interests, feelings and actions
• a shared sense of common origins or ancestry, and
• a common geographic origin. Māori in this report refers to the Māori ethnic group</td></tr>
<tr><td>Source standards:</td><td colspan="3">Ethnicity New Zealand Standard Classification 2005, ETHNIC05 V1.0, 01/06/2005</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>5</td><td>Representational layout:</td><td>N(5)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Conditional. Record if second ethnicity offered by patient.</td></tr>
<tr><td>Data domain:</td><td colspan="3">See the Ministry of Health’s Ethnicity Data Protocols for the Health and Disability Sector at http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector for a list of valid codes.</td></tr>
<tr><td>Guide for use:</td><td colspan="3">Ethnicity 2 should record the patient’s second stated ethnicity - the second ethnicity offered by the patient.
Refer to Ethnicity Data Protocols for the Health and Disability Sector, Ministry of Health, 2004 for more guides to use.</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

2.15 *Ethnicity 3*

<table>
<tr><td>Definition:</td><td colspan="3">Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group.
An ethnic group is made up of people who have some or all of the following characteristics:
• a common proper name
• one or more elements of common culture that need not be specified, but may include
• religion, customs, or language
• unique community of interests, feelings and actions
• a shared sense of common origins or ancestry, and
• a common geographic origin. Māori in this report refers to the Māori ethnic group.</td></tr>
<tr><td>Source standards:</td><td colspan="3">Ethnicity New Zealand Standard Classification 2005, ETHNIC05 V1.0, 01/06/2005</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>5</td><td>Representational layout:</td><td>N(5)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Conditional. Record if third ethnicity offered by patient.</td></tr>
<tr><td>Data domain:</td><td colspan="3">See the Ministry of Health’s Ethnicity Data Protocols for the Health and Disability Sector at http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector for a list of valid codes.</td></tr>
<tr><td>Guide for use:</td><td colspan="3">Ethnicity 3 should record the patient’s third stated ethnicity - the third ethnicity offered by the patient.
Refer to Ethnicity Data Protocols for the Health and Disability Sector, Ministry of Health, 2004 for more guides to use.</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

2.16 Ethnicity 4

<table>
<tr><td>Definition:</td><td colspan="3">Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group.
An ethnic group is made up of people who have some or all of the following characteristics:
• a common proper name
• one or more elements of common culture that need not be specified, but may include
• religion, customs, or language
• unique community of interests, feelings and actions
• a shared sense of common origins or ancestry, and
• A common geographic origin. Māori in this report refers to the Māori ethnic group.</td></tr>
<tr><td>Source standards:</td><td colspan="3">Ethnicity New Zealand Standard Classification 2005, ETHNIC05 V1.0, 01/06/2005</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>5</td><td>Representational layout:</td><td>N(5)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Conditional. Record if fourth ethnicity offered by patient.</td></tr>
<tr><td>Data domain:</td><td colspan="3">See the Ministry of Health’s Ethnicity Data Protocols for the Health and Disability Sector at http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector for a list of valid codes.</td></tr>
<tr><td>Guide for use:</td><td colspan="3">Ethnicity 4 should record the patient’s fourth stated ethnicity - the fourth ethnicity offered by the patient.
Refer to Ethnicity Data Protocols for the Health and Disability Sector, Ministry of Health, 2004 for more guides to use.</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

2.17 *Ethnicity 5*

<table>
<tr><td>Definition:</td><td colspan="3">Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group.
An ethnic group is made up of people who have some or all of the following characteristics:
• a common proper name
• one or more elements of common culture that need not be specified, but may include
• religion, customs, or language
• unique community of interests, feelings and actions
• a shared sense of common origins or ancestry, and
• a common geographic origin. Māori in this report refers to the Māori ethnic group.</td></tr>
<tr><td>Source standards:</td><td colspan="3">Ethnicity New Zealand Standard Classification 2005, ETHNIC05 V1.0, 01/06/2005</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>5</td><td>Representational layout:</td><td>N(5)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Conditional. Record if fifth ethnicity offered by patient.</td></tr>
<tr><td>Data domain:</td><td colspan="3">See the Ministry of Health’s Ethnicity Data Protocols for the Health and Disability Sector at http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector for a list of valid codes.</td></tr>
<tr><td>Guide for use:</td><td colspan="3">Ethnicity 5 should record the patient’s fifth stated ethnicity - the fifth ethnicity offered by the patient.
Refer to Ethnicity Data Protocols for the Health and Disability Sector, Ministry of Health, 2004 for more guides to use.</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

2.18 *Ethnicity 6*

Definition:	Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group. An ethnic group is made up of people who have some or all of the following characteristics: • a common proper name • one or more elements of common culture that need not be specified, but may include • religion, customs, or language • unique community of interests, feelings and actions • a shared sense of common origins or ancestry, and • a common geographic origin. Māori in this report refers to the Māori ethnic group.		
Source standards:	Ethnicity New Zealand Standard Classification 2005, ETHNIC05 V1.0, 01/06/2005		
Data type:	Numeric	**Representational class:**	Code
Field size:	5	**Representational layout:**	N(5)
Obligation:	Conditional. Record if sixth ethnicity offered by patient.		
Data domain:	See the Ministry of Health's Ethnicity Data Protocols for the Health and Disability Sector at http://www.health.govt.nz/publication/ethnicity-data-protocols-health-and-disability-sector for a list of valid codes.		
Guide for use:	Ethnicity 6 should record the patient's sixth stated ethnicity - the sixth ethnicity offered by the patient. Refer to *Ethnicity Data Protocols for the Health and Disability Sector*, Ministry of Health, 2004 for more guides to use.		
Verification rules:			

2.19 *Place of Death*

Definition:	The location of the patient at their death.		
Source standards:			
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Conditional. Record if the patient is known to be deceased		
Data domain:	(see table below)		
Guide for use:	Record if the patient is known to be deceased		
Verification rules:			

Data domain:

Value	Meaning
7	Correctional Facility
3	Hospice Inpatient Unit
4	Private Hospital
1	Private residence (including unit in retirement village)
5	Public Hospital
6	Residential aged care, high level care (hospital level care)
2	Residential aged care, low level care (level 2 rest home)
99	Other

2.20 Date of Death

Definition:	The date on which the patient died. Sourced from Births, Deaths and Marriages.		
Source standards:	HL7 v2.4 DT – date		
Data type:	Date	**Representational class:**	Full date
Field size:	8	**Representational layout:**	CCYY[MM[DD]]
Obligation:	Conditional. Record if the patient is known to be deceased and the date of death is known.		
Data domain:	Valid date		
Guide for use:	Must be on or after the Date of Birth, and before the current date. If diagnosed post mortem, the Date of Death is the Diagnosis Date. The CCYY component of the date is mandatory (if known). MM is conditional (use if known). DD is conditional (use if known and MM has been recorded).		
Verification rules:	> Patient: Date of Birth		

3 EPISODE OF CARE

An episode of care is a period of care when patients and their families receive services to improve their quality of life. Care of individual patients may occur in discrete episodes, which may be separated in time and location. Each episode of care will involve one or more service contacts.

The data elements for 'Episode of care' are:

1. Episode ID
2. NHI Number
3. Referral Date
4. Referral Source
5. Episode Start Date
6. Episode Start Accommodation
7. Episode Start Support
8. Proposed Model of Care
9. Episode End Date
10. Episode End Mode
11. Episode End Accommodation
12. Episode End Support
13. Provider Organisation
14. End of Life Care Plan Used
15. End of Life Care Plan

3.1 Episode ID

Definition:	Unique identifier for this record		
Source standards:			
Data type:	Numeric	**Representational class:**	numeric
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	System generated primary key for this record		
Verification rules:			

3.2 NHI Number

Definition:	Unique 7-character identification number assigned to a healthcare user by the National Health Index (NHI) database.		
Source standards:	National Health Index Data Dictionary, v5.3, July 2009		
Data type:	Alphanumeric	**Representational class:**	Text
Field size:	7	**Representational layout:**	AAANNNN
Obligation:	Mandatory		
Data domain:	Valid NHI number		
Guide for use:	Foreign key to related record in the Patient entity		
Verification rules:			

3.3 Referral Date

Definition:	The date the agency received a referral for this patient/client from another party for this episode of palliative care services.		
Source standards:	HL7 v2.4 DT - date		
Data type:	Date	**Representational class:**	Full date
Field size:	8	**Representational layout:**	CCYYMMDD
Obligation:	Optional		
Data domain:	Valid date		
Guide for use:	Time may elapse between the date the referral was received and the date it was accepted but it is the date the referral was received that should be recorded for this data item		
Verification rules:	Date of referral must be: > Patient: Date of Birth		

3.4 *Referral Source*

Definition:	Source of referral for this episode		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 2, 2006, Values from Version 3, 2012.		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Mandatory		

Data domain:

Value	Meaning
61	Community services (DHB based – District Community Nurse)
40	General Practice team
21	Hospice palliative care service
12	Māori Health Services
20	Private hospital
10	Public Hospital
71	Residential aged care, high level care (hospital level care)
70	Residential aged care, low level care (level 2 rest home)
80	Self, carer(s), family, friends, whānau
50	Specialist private medical practitioner
99	Other

Guide for use:	If unsure of the employment of the General Practitioner (GP) as the referral source, select either 70 or 71 for Residential Aged Care (eg, visit by a GP at the request of a patient at a Residential Aged Care facility, or a GP employed by a Residential Aged Care facility).
Verification rules:	

3.5 *Episode Start Date*

Definition:	Episode Start Date is the date of the first interaction between this agency and the patient/client. If after assessment the patient is not deemed to be suitable for palliative care services in this agency, the assessment will be recorded as a Service Contact and the Episode will end.		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 3, 2012		
Data type:	Date	**Representational class:**	Full date
Field size:	8	**Representational layout:**	CCYYMMDD
Obligation:	Mandatory		
Data domain:	Valid date		
Guide for use:			
Verification rules:	Episode start date must be: >= Episode of Care: Date of Referral >= Patient:Date of Birth <= Patient:Date of Death		

3.6 *Episode Start Accommodation*

<table>
<tr><td>Definition:</td><td colspan="3">Type of usual accommodation at the commencement of the episode</td></tr>
<tr><td>Source standards:</td><td colspan="3">Palliative Care Outcomes Collaboration (PCOC), Australia, Version 3, 2012</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>3</td><td>Representational layout:</td><td>N(3)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Mandatory</td></tr>
<tr><td>Data domain:</td><td colspan="3"><table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Private residence (including unit in retirement village)</td></tr><tr><td>2</td><td>Residential aged care, low level care (level 2 rest home)</td></tr><tr><td>3</td><td>Residential aged care, high level care (hospital level care)</td></tr><tr><td>4</td><td>Correctional facility</td></tr><tr><td>5</td><td>Public hospital</td></tr><tr><td>6</td><td>Hospice Inpatient Unit</td></tr><tr><td>99</td><td>Other</td></tr></table></td></tr>
<tr><td>Guide for use:</td><td colspan="3">Implementation guide: Choosing options 2 or 3 of Episode Start Accommodation should result in options 1, 2, and 3 of Episode Start Support being unavailable.</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

3.7 *Episode Start Support*

Definition:	Level of support received at the commencement of the episode		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 2, 2006		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Mandatory		
Data domain:	see table below		
Guide for use:	see table below		
Verification rules:			

Data domain:

Value	Meaning
1	Lives alone with no care/support provided
2	Lives with others with no care/support provided
3	Lives alone with external professional support
4	Lives with others who provide care/support
5	Lives with others with external professional support
6	Other arrangements
99	Not stated/inadequately described/not applicable

Guide for use:

Value and Meaning	Guide for Use
3 “Lives alone with external professional support”	Those who live alone but receive external professional support.
4 “Lives with others who provide care/support”	Those who live in the company of others and rely on them for care or support.
4. Lives with others who provide care/support.	A patient living in residential care at the start of this episode of care should have this data element record as 4
5 “Lives with others with external professional support”	Those who live in the company of others but do not rely on them for care or support. In this instance, the support received is external professional support.

Implementation guide: Choosing options 2 or 3 of Episode Start Accommodation should result in options 1, 2, and 3 of Episode Start Support being unavailable

3.8 *Proposed Model of Care*

Definition:	The type of care planned at the start of this episode of care		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 2, 2006		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Mandatory		
Data domain:	**Value**	**Meaning**	
	1	Sole care. The provider is the primary provider and has responsibility for the provision of care.	
	2	Shared care with another service provider(s) (cancer care, respiratory, GP, MND, community health)	
	3	Consultation/liaison with another service provider	
Guide for use:	The model of care may change during the episode but this data item is intended to reflect the type of care planned at the start of the episode.		
Verification rules:			

3.9 *Episode End Date*

Definition:	The date of episode end		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 3, 2012		
Data type:	Date	**Representational class:**	Full date
Field size:	8	**Representational layout:**	CCYYMMDD
Obligation:	Optional		
Data domain:	Valid date – the date of discharge or transfer or the date of death where grief or bereavement counselling is not immediately required. If grief or bereavement counselling is subsequently identified a new episode of care will need to be established.		
Guide for use:	It is important that Episode End Date is recorded in the same way wherever it is recorded. For that reason, Episode End Date should be recorded as the later of Date of Discharge, Date of Transfer, Date of Death (where grief or bereavement counselling is not immediately required). Services provided after a patient's death (e.g. grief counselling) should be recorded within a new Episode of Care where they have been provided some time after a patient's death. Where the Episode of Care was started after the patient's death, the Episode End Date should be recorded as the date of the last Service Contact for that Episode of Care.		
Verification rules:	>= Episode of Care: Episode Start Date		

3.10 Episode End Mode

Definition:	How this episode ended.		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 3, 2012		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Conditional – mandatory if Episode End Date present		
Data domain:	Value: Meaning 11: Discharged 13: Deceased 14: Transferred to other palliative care service 99: Other		
Guide for use:	Implementation guide: Choosing option 13 should result in all options of Episode End Accommodation being unavailable.		
Verification rules:			

Data domain:

Value	Meaning
11	Discharged
13	Deceased
14	Transferred to other palliative care service
99	Other

3.11 Episode End Accommodation

Definition:	Type of usual accommodation at episode end.		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 3, 2012		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Conditional – mandatory if Episode End Date present		
Data domain:	(see below)		
Guide for use:	Implementation guide: Choosing options 2 or 3 of Episode End Accommodation should result in options 1, 2, and 3 of Episode End Support being unavailable.		
Verification rules:			

Data domain:

Value	Meaning
1	Private residence (including unit in retirement village)
2	Residential aged care, low level care (level 2 rest home)
3	Residential aged care, high level care (hospital level care)
4	Correctional facility
99	Other

3.12 Episode End Support

Definition:	Level of support received at episode end.		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 2, 2006		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Conditional – mandatory if Episode End Date present		

Data domain:

Value	Meaning
1	Lives alone with no care/support provided
2	Lives with others with no care/support provided
3	Lives alone with external support
4	Lives with others who provide care/support
5	Lives with others with external support
6	Other arrangements
99	Not stated/inadequately described/not applicable

Guide for use:

Value and Meaning	Guide for Use
3 "Lives alone with external professional support"	Those who live alone but receive external professional support.
4 "Lives with others who provide care/support"	Those who live in the company of others and rely on them for care or support.
4. Lives with others who provide care/support.	A patient living in residential care at the start of this episode of care should have this data element record as 4
5 "Lives with others with external professional support"	Those who live in the company of others but do not rely on them for care or support. In this instance, the support received is external professional support.

Implementation guide: Choosing options 2 or 3 of Episode End Accommodation should result in options 1, 2, and 3 of Episode End Support being unavailable.

Verification rules:

3.13 *Provider Organisation*

Definition:	A code that uniquely identifies a healthcare facility. A healthcare facility is a place, which may be a permanent, temporary, or mobile structure that healthcare users attend or are resident in for the primary purpose of receiving healthcare or disability support services. This definition excludes supervised hostels, halfway houses, staff residences, and rest homes where the rest home is the patient's usual place of residence.		
Source standards:	N/A		
Data type:	Alphanumeric	**Representational class:**	Code
Field size:	6	**Representational layout:**	FXXNNN
Obligation:	Mandatory		
Data domain:	Validated against the Health Practitioner Index (HPI) Data Set		
Guide for use:	F is a constant prefix. X is either an alpha or a numeric. The Facility Identifier is assigned by the HPI system at the time that the facility record in the HPI is created.		
Verification rules:			

3.14 *End of Life Care Plan Used*

Definition:	Indicates whether an End of Life care plan was used		
Source standards:	N/A		
Data type:	Boolean	**Representational class:**	N/A
Field size:	1	**Representational layout:**	Y/N
Obligation:	Mandatory		
Data domain:			
Guide for use:	Y (Yes/True) if an End of Life Care Plan was used N (No/False) if an End of Life Care Plan was not used		
Verification rules:			

3.15 *End of Life Care Plan*

<table>
<tr><td>Definition:</td><td colspan="3">Name and/or description of the End of Life care plan used</td></tr>
<tr><td>Source standards:</td><td colspan="3"></td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>3</td><td>Representational layout:</td><td>N(3)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Mandatory if “End of Life Care Plan Used” is set to Yes/True</td></tr>
<tr><td>Data domain:</td><td colspan="3"><table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Liverpool care pathway for the dying NZ adaptation
http://www.lcpnz.org.nz/pages/home/</td></tr><tr><td>99</td><td>Other</td></tr></table></td></tr>
<tr><td>Guide for use:</td><td colspan="3">Should be completed if “End of life care plan used” is set to True</td></tr>
<tr><td>Verification rules:</td><td colspan="3">Available only if the “End of Life Care Plan Used” is set to True</td></tr>
</table>

4 SERVICE CONTACT

Service contacts are services that are provided to, or on behalf of, the patient and/or their carer(s)/family/friends, or whānau that result in a dated entry being made in the client record, except where the service is primarily of an administrative nature (for example, making an appointment on behalf of a client). A palliative care client may receive more than one service contact per day, and may receive different types of assistance within one service contact. The types of care provided at a service contact may, for example, include medical care, nursing care and spiritual care. It is not intended that the burden of collection exceeds the value of collection, so record only those contacts that have value as part the clinical and service record.

The data elements for 'Service contact' are:

1. Service Contact ID
2. Episode ID
3. Service Contact Start Date
4. Recipient Type
5. Delivery Setting
6. Contact Method
7. Service Contact End Date

4.1 Service Contact ID

Definition:	Unique identifier for this record		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	System generated primary key for this record		
Verification rules:			

4.2 Episode ID

Definition:	The identifier for the episode of care record to which this service contact relates		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	Foreign key to related record in the Episode of Care entity		
Verification rules:			

4.3 *Service Contact Start Date*

Definition:	The date the contact started		
Source standards:	Australian Institute of Health and Welfare (AIHW), Australia, 2007		
Data type:	Date	**Representational class:**	Full date
Field size:	8	**Representational layout:**	CCYYMMDD
Obligation:	Mandatory		
Data domain:	Valid date		
Guide for use:			
Verification rules:	This field must be: >= Episode of Care: Episode Start Date, and <= Episode of Care: Episode End Date		

4.4 *Recipient Type*

<table>
<tr><td>Definition:</td><td colspan="3">Categorisation of the recipient. It is not only the patient who may receive a service in this context</td></tr>
<tr><td>Source standards:</td><td colspan="3">Australian Institute of Health and Welfare (AIHW), Australia, 2007</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>3</td><td>Representational layout:</td><td>N(3)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Mandatory</td></tr>
<tr><td>Data domain:</td><td colspan="3"><table>
<tr><th>Value</th><th>Meaning</th></tr>
<tr><td>1</td><td>Patient</td></tr>
<tr><td>2</td><td>Patient and carer(s), family, friends, whānau</td></tr>
<tr><td>3</td><td>Carer(s), family, friends, whānau</td></tr>
<tr><td>4</td><td>Other professional(s)/service provider(s) only</td></tr>
<tr><td>5</td><td>Other recipient</td></tr>
<tr><td>99</td><td>Unknown</td></tr>
</table></td></tr>
<tr><td>Guide for use:</td><td colspan="3">Where one care provider interacts with another regarding the care of a patient, 4 “Other professional(s)/service provider(s) only” should be selected as the Recipient Type</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

4.5 Delivery Setting

Definition:	The setting in which the service contact took place.		
Source standards:	Australian Institute of Health and Welfare (AIHW), Australia, 2007		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Mandatory		
Data domain:	(see table below)		
Guide for use:	Where one care provider interacts with another regarding the care of a patient other than with the patient, select 7 “Not applicable (patient/ client not present at service contact)”		
Verification rules:			

Data domain:

Value	Meaning
12	Day Activities programmes
11	Correctional Facility
3	Hospice inpatient unit
4	Hospice outpatient clinic
7	Not applicable (patient/client not present at service contact)
6	Private hospital inpatient unit
9	Private hospital outpatient clinic
1	Private residence
5	Public hospital inpatient unit
8	Public hospital outpatient clinic
10	Residential aged care, high level care (hospital level care)
2	Residential aged care, low level care (level 2 rest home)
99	Other

4.6 Contact Method

Definition:	The way in which the service contact took place		
Source standards:	Australian Institute of Health and Welfare (AIHW), Australia, 2007		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Mandatory		
Data domain:	(see table below)		
Guide for use:			
Verification rules:			

Data domain:

Value	Meaning
1	Face-to-face
2	Telephone
3	Written (including email, txt)
4	Tele/video/web conference
99	Other

4.7 Service Contact End Date

Definition:	The date the contact ended		
Source standards:	Australian Institute of Health and Welfare (AIHW), Australia, 2007		
Data type:	Date	**Representational class:**	Full date
Field size:	8	**Representational layout:**	CCYYMMDD
Obligation:	Optional		
Data domain:	Valid date		
Guide for use:			
Verification rules:	This field must be: >= Episode of Care: Episode Start Date, and <= Episode of Care: Episode End Date		

5 DIAGNOSIS

The data record Diagnosis contains details of diagnoses. It should include the principal diagnosis and any clinically relevant additional diagnoses.

The data elements for 'Diagnosis' are:

1. Diagnosis ID
2. Episode ID
3. Diagnosis
4. Principal Diagnosis

5.1 Diagnosis ID

Definition:	Unique identifier for this record		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	System generated primary key for this record		
Verification rules:			

5.2 Episode ID

Definition:	The identifier for the episode of care record to which this diagnosis relates		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	Foreign key to related record in the Episode of Care entity		
Verification rules:			

5.3 *Diagnosis*

Definition:	A diagnosis clinically relevant to the patient's care. The Principal Diagnosis field indicates whether this diagnosis is the principal diagnosis or an additional diagnosis.		
Source standards:	Palliative Care Outcomes Collaboration (PCOC), Australia, Version 3, 2012		
Data type:	Numeric	**Representational class:**	Code
Field size:	3	**Representational layout:**	N(3)
Obligation:	Mandatory		

Data domain:

Value	Meaning
206	Alzheimer's Dementia
101	Cancer - Bone and Soft Tissue
102	Cancer - Breast
103	Cancer – CNS
104	Cancer - Colorectal
112	Cancer - Gynaecological
106	Cancer - Haematological
107	Cancer - Head and Neck
108	Cancer – Lung
113	Cancer - Melanoma / Skin
105	Cancer - Other GIT
180	Cancer - Other Primary Malignancy
111	Cancer - Other Urological Malignancy
109	Cancer - Pancreas
110	Cancer - Prostate
114	Cancer - Unknown Primary
201	Cardiovascular Disease
211	Diabetes and its complications
203	End Stage Kidney Disease (Renal Disease)
210	End Stage Liver Disease (Hepatic disease)
202	HIV/AIDS
100	Malignant – not further defined
205	Motor Neurone Disease
213	Multi-organ Failure
200	Non Malignant – not further defined
207	Other Dementia
208	Other Neurological Disease
280	Other non-malignancy
209	Respiratory Disease
212	Sepsis
204	Stroke
999	Unknown

Guide for use:	There is no need to record an ICD-10 or SNOMED-CT code for diagnosis in this data specification. Should there be a need, these classifications can be mapped to either ICD-10 or SNOMED-CT at a later date.
Verification rules:	

5.4 Principal Diagnosis

Definition:	Indicates whether a diagnosis was the principal diagnosis. The Principal Diagnosis is the broad diagnostic group established after study to be mainly responsible for occasioning the patient's episode of care		
Source standards:	N/A		
Data type:	Boolean	**Representational class:**	N/A
Field size:	1	**Representational layout:**	Y/N
Obligation:	Mandatory		
Data domain:			
Guide for use:	Yes (Y) if the diagnosis was the principal diagnosis No (N) if the diagnosis was an additional diagnosis.		
Verification rules:			

6 CONTACT PURPOSE

The data record Contact Purpose contains the purpose descriptions applicable to the related Service Contact record.

The data elements for 'Contact Purpose' are:

1. Contact Purpose ID
2. Service Contact ID
3. Contact Purpose

6.1 Contact Purpose ID

Definition:	Unique identifier for this record		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	System generated primary key for this record		
Verification rules:			

6.2 Service Contact ID

Definition:	The identifier for Service Contact record to which this Contact Purpose relates		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	Foreign key to related record in the Service Contact entity		
Verification rules:			

6.3 Contact Purpose

<table>
<tr><td>Definition:</td><td colspan="3">The purpose of the Service Contact record to which this Contact Purpose record relates</td></tr>
<tr><td>Source standards:</td><td colspan="3">Australian Institute of Health and Welfare (AIHW), Australia, 2007</td></tr>
<tr><td>Data type:</td><td>Numeric</td><td>Representational class:</td><td>Code</td></tr>
<tr><td>Field size:</td><td>3</td><td>Representational layout:</td><td>N(3)</td></tr>
<tr><td>Obligation:</td><td colspan="3">Mandatory</td></tr>
<tr><td>Data domain:</td><td colspan="3">
<table>
<tr><th>Value</th><th>Meaning</th></tr>
<tr><td>3</td><td>Case management and/or care coordination</td></tr>
<tr><td>2</td><td>Clinical care</td></tr>
<tr><td>1</td><td>Comprehensive assessment</td></tr>
<tr><td>18</td><td>Day activities programmes</td></tr>
<tr><td>12</td><td>Education of the patient and family/whānau</td></tr>
<tr><td>13</td><td>Family/ whānau meeting</td></tr>
<tr><td>9</td><td>Grief and loss support</td></tr>
<tr><td>14</td><td>Inpatient admission</td></tr>
<tr><td>16</td><td>Inpatient discharge</td></tr>
<tr><td>15</td><td>Multi-disciplinary review</td></tr>
<tr><td>5</td><td>Personal care</td></tr>
<tr><td>10</td><td>Psycho-emotional support</td></tr>
<tr><td>6</td><td>Social support</td></tr>
<tr><td>4</td><td>Spiritual care or support</td></tr>
<tr><td>98</td><td>Other</td></tr>
<tr><td>99</td><td>Not stated</td></tr>
</table>
</td></tr>
<tr><td>Guide for use:</td><td colspan="3">Implementation of this data item should permit multiple items to be selected where the visit has more than one purpose.

Where a family meeting has taken place and multiple providers were present, record as one service contact (with multiple providers recorded)

A multi-disciplinary meeting should not be assumed as having taken place when a Comprehensive assessment is selected. Record both explicitly.

Refer to Appendix B – Contact Purpose for more detail of each of the values in this data domain.</td></tr>
<tr><td>Verification rules:</td><td colspan="3"></td></tr>
</table>

7 PROVIDER OCCUPATION

The data record Provider Occupation contains the occupation descriptions of the providers who participated in the related Service Contact record.

The data elements for 'Provider Occupation' are:

1. Provider Occupation ID
2. Service Contact ID
3. Provider Occupation

7.1 Provider Occupation ID

Definition:	Unique identifier for this record		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	System generated primary key for this record		
Verification rules:			

7.2 Service Contact ID

Definition:	The identifier for the Service Contact record to which this Provider Occupation record relates		
Source standards:			
Data type:	Numeric	**Representational class:**	Number
Field size:	11	**Representational layout:**	N(11)
Obligation:	Mandatory		
Data domain:	Number		
Guide for use:	Foreign key to related record in the Service Contact entity		
Verification rules:			

7.3 Provider Occupation

Definition:	The occupation of the Service Contact provider		
Source standards:	Australian Institute of Health and Welfare (AIHW), Australia, 2007		
Data type:	Numeric	Representational class:	Code
Field size:	3	Representational layout:	N(3)
Obligation:	Mandatory		

Data domain:

Value	Meaning
19	Complementary therapist
12	Dietician
6	Grief/Bereavement counsellor
14	Māori health worker
1	Medical practitioner
3	Nurse
20	Nurse practitioner
9	Occupational therapist
16	Other counsellor
15	Personal care assistant/nurse assistant/ health care assistant
18	Pharmacist
8	Physiotherapist
13	Podiatrist
7	Psychologist
11	Social worker
10	Speech therapist
5	Spiritual carer
17	Volunteer
99	Other occupation

Guide for use:	Implementation of this data item should permit multiple items to be selected where more than one provider is involved in the Service Contact. Where one care provider interacts with another regarding the care of a patient, 4 “Other professional(s)/service provider(s) only” should be selected as the Service Contact: Recipient Type
Verification rules:	

APPENDIX A – GLOSSARY

Term	Description
AIHW	Australian Institute of Health and Welfare
METeOR	An application maintained by the Australian Institute of Health and Welfare where metadata is stored, managed and disseminated.
NHI	National Health Index – unique identifier for NZ health care users
PCOC	Palliative Care Outcomes Collaboration

APPENDIX B – CONTACT PURPOSE

Value	Meaning
1	Comprehensive assessment The needs, strengths, understandings and expectations of the patient, their caregiver/s and family/whānau are documented and reflected upon in the assessment. This incorporates the physical, spiritual, social and emotional parameters. Services that are appropriate to the level/needs of care for the patient/family/whānau are offered and explained.
2	Clinical care The provision of medical and nursing care according to the assessed care requirements of the patient.
3	Case management and/or care coordination Includes, but not limited to, case conference activities or discussion/review of a case between two or more service providers, liaison with, and referral to other service providers, and communication with patient and/or family/whānau.
4	Spiritual care or support Refers to attending to spiritual matters of patient and family/whānau including but not limited to beliefs, meaning, identity and hope.
5	Personal care Refers to assistance with daily self-care tasks such as but not limited to eating, bathing, toileting and grooming, transferring in and out of bed
6	Social support Refers to the assessment, discussion and/or liaison with other services in order to address matters including but not limited to income, benefits, home help eligibility, and the enabling of independence of the patient or family/whānau.
9	Grief and loss support Emotional and spiritual support focussed on loss and grief includes the patient, the caregiver/s and family/whānau. This may begin when a life limiting illness is diagnosed. On-going support based on self-identified need is offered to the caregiver/s and family.
10	Psycho-emotional support Concerned with the psychological and emotional well-being of the patient and their family/whānau including, but not limited to issues of self-esteem, insight into and adaption to illness and its consequences, communication and impact on social functioning.
12	Education of the patient and family/whānau Education going beyond the normal procedural explanations given to patients and their families. Should encompass the determination of what the patients and their families wish to learn.
13	Family/whānau meeting Where family/ whānau as defined by the patient are invited to discuss with members of the MDT, their understanding and concerns that relate to the preceding or current clinical events, and/or the planning care needs with the expected course of the patient in mind.
14	Inpatient admission The admission of a patient to an inpatient specialist palliative care inpatient unit.
15	Multi-disciplinary review The appraisal of a patient's comprehensive assessment by the Multi-disciplinary team in order to develop a holistic approach to the management options available to the patient and family/whānau.
16	Inpatient discharge The discharge of a patient from a specialist palliative care inpatient unit.
18	Day Activities Programme The attendance of a patient at a Hospice/specialist palliative care day programme that may include, but not be limited to focused activities for maintaining independence, promoting well-being, providing information, therapeutic or respite care (non clinical/medical programmes).
98	Other

Value	Meaning
	Any contact purpose other than those listed in this table.
99	Not stated